STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	03/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPARK HEALTHCARE CENTER	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 18, 19, 20, 21, and 22, 2013 Facility number: 000473 Provider number: 155389 Aim number: 100290410 Survey team: Donna M. Smith, RN-TC Mary Jane Fischer, RN Maureen Newton, RN Cynthia Stramel, RN Gloria Bond, RN Census bed type: SNF/NF: 47 Total: 47 Census payor type: Medicare: 23 Medicaid: 23 Other: 1 Total: 47 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on 04/03/2013 by Brenda Nunan, RN.	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000156 SS=A	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure a telephone consent for ABN (Advance Beneficiary Notice of Noncoverage) was followed up with an attempt to obtain the resident's responsible party's signature for 1 of 1 telephone consent in a sample of 3 notices of non-coverage reviews (Resident #36). Findings included: Resident #36's notice for Medicare non-coverage was reviewed on 3/21/2013. The record indicated, on 10/15/12, the resident "refused to sign, wasn't understanding the notice..." This same record also indicated the resident's responsible party was notified via telephone on this same day (10/15/12), and a phone consent was obtained. On 3/22/2013 at 9:15 a.m., during an interview, the Social Service Director indicated she received phone approval from the resident's responsible party on 10/15/12 but did not obtain a signed consent. The "DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for	F000156	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after 4/16/13. (1) After telephone consent is obtained a copy of the ABN notice will be sent with return receipt requested. This will be noted in the beneficiary record and the receipt will be attached to a copy of the ABN notice for retention in the file. (2) Review of records shows no other resident was affected. (3) A new policy has been put into place requiring that after telephone consent is obtained a copy of the ABN notice will be sent with return receipt requested. This will be noted in the beneficiary record and the receipt will be attached to a copy of the ABN notice for retention in the file. (4) Administration will monitor weekly at the Medicare meeting. This procedure will apply to all Medicare beneficiaries requiring notices of non coverage.	04/16/2013

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	Medicare & Medicaid Services Second Edition," dated April 2011, indicated the following related to ABN's: "...When delivery is not in-person, the contact must be documented in the beneficiary's records. To be considered effective, the beneficiary cannot dispute such contact. Telephone contacts must be followed immediately by either a hand-delivered, mailed, e-mailed, or faxed notice. The beneficiary or representative must sign and retain the notice and send a copy of this signed notice to the health care provider for retention in the beneficiary's record. The provider/supplier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the health care provider must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself...." 3.1-4(f)(3)			

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F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure a resident's dignity was maintained related to wet clothing and nasal congestion management for 2 of 3 residents observed who met the CQLI [Criteria for Quality of Life and Care] in a sample of 3 (Resident #20 and #32). Findings include: 1. The record for Resident #20 was reviewed on 03-19-13 at 8:00 a.m. Diagnoses included, but were not limited to, mixed dementia, seizure disorder, diabetes mellitus, and hypertension. These diagnoses remained current at the time of the record review. Review of the resident's minimum data set assessment, dated 02-14-13, indicated the resident was "always incontinent of bowel and bladder." The resident's current plan of care, originally dated 11-23-12, indicated	F000241	(1) Nursing staff will be in-serviced regarding checking affected residents for incontinence every two hours and as needed.Nursing staff will also be in-serviced regarding the resident's right to dignity. (2) Resident's MDS assessments will be used to identify other resident's with the potential to be affected. (3) The DON/ADON/Evening Shift Supervisor will do rounds every two hours for two weeks during day shift/evening shift. The Night Shift Supervisor will do rounds during night shift every two hours for two weeks. After that the DON/ADON will do a randomly timed round every day during day shift indefinitely. The Evening Shift Supervisor will do a randomly timed round every evening during evening shift indefinitely. The Night Shift Supervisor will do a randomly timed round during night shift indefinitely. Staff that are not properly checking for incontinence and not maintaining resident's dignity will be counseled and re-educated. (4) The DON/ADON will monitor the corrective action by doing	04/16/2013

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	the resident had a "self care deficit requiring prompts and cues - total to extensive assist for hygiene and toileting." On 03-18-13 at 10:15 a.m., the resident was observed seated in the resident's room. Upon entrance to the room, by permission of the resident, a strong urine odor permeated the air. The resident's sweat pants were observed soaked with moisture across the front and upper legs of the pants. The resident indicated, "I think I [expletive for urination]." The nursing staff was informed of the resident's incontinent episode. During an observation on 03-21-13 at 1:00 p.m., there was a distinct urine odor as the resident passed through the dining room. Certified Nurse Aide (CNA) #18 was questioned about the resident's incontinence, and the certified nurses aide indicated the resident was not incontinent. A request was made to check the resident for incontinence. During an interview on 03-21-13 at 1:30 p.m., the CNA indicated the resident was wet, "it was just pee, [resident] urine is very strong."		rounds every two hours for two weeks during day shift/evening shift. The Night Shift Supervisor will do rounds during night shift every two hours for two weeks. After that the DON/ADON will do a randomly timed round every day during day shift indefinitely. The Evening Shift Supervisor will do a randomly timed round every evening during evening shift indefinitely. The night shift supervisor will do a randomly timed round during night shift indefinitely.	

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	2. The record for Resident #32 was reviewed on 03-20-13 at 9:00 a.m. Diagnoses included, but were not limited to, dementia, history of breast cancer, hypertension, diabetes mellitus, depression and aphasia. These diagnoses remained current at the time of the record review. The resident's current plan of care, originally dated 12-20-11, indicated the resident "required extensive to total care for all personal care and Activities of Daily Living." During an observation on 03-19-13 at 8:45 a.m., the resident was transported to the common area of the East Unit. The resident had thick stands of mucus dripping from her nose to pants. The nursing staff did not intervene to assist the resident. A therapy staff member walked past the resident and was alerted to the resident's needs. During an observation on 03-20-13 at 8:00 a.m., the resident was transported from her room to the assist dining room in her wheelchair. The resident was observed with "white matter/debris" along the lower lip. The nursing staff did not intervene to clean the resident's mouth/lips prior to the breakfast meal.			

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	On 03-21-13 at 12:41 p.m., the resident was seated in the wheelchair in her room. The resident had copious amounts of mucus coming from the nares and dripping onto the blanket which had been placed across the resident's lap. 3.1-3(t)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to initiate a care plan related to compromised heels in a timely manner for 1 of 2 residents reviewed in a sample of 7 residents with pressure ulcers and failed to initiate a care plan related to the medication, Aranesp (antianemic) for 1 of 10 residents reviewed for unnecessary medications (Resident #9). Findings include: 1.) Resident #9's record was	F000279	(1) Affected resident's skin sheets will be reviewed and anyone that does not have a CP in place for compromised heels will receive one. Any resident receiving Aranesp will have a CP related to the use of Aranesp. (2) Skin sheets and treatment/preventative methods have been reviewed to identify other residents with the potential to be affected.During the review it was found that consistent timely interventions have been put in place and no other resident was found to be affected. Medication Records will be reviewed for other resident's receiving Aranesp that	04/16/2013

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	reviewed on 3/21/13 at 9:45 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, hypertension, and Diabetic Mellitus Type II. The admission Minimum Data Set assessment, dated 12/18/12, indicated the resident was at risk for skin breakdown with no unhealed pressure ulcers indicated and with a diabetic foot ulcer. The resident was discharged on 3/19/13. The admission "Skin Check" record, dated 12/6/12, indicated on a body diagram the resident's bilateral heels were "soft & mushy" with skin peeling off of her left heel. The "PRESSURE ULCER REPORT AND OTHER SKIN CONDITION REPORT" record indicated the following related to the resident's heels: The first documentation related to the resident's heels was on 1/15/13 where both heels were indicated as red with peeling skin with no measurements included; On 1/22/13 both heels were indicated as having decreased redness but continued with areas of peeling skin and no measurements included;		have the potential to be affected. (3) The DON/ADON will review skin sheets weekly and will view skin assessments of new admissions within 24 hours of admission to ensure that care plans related to compromised heels are initiated in a timely manner. The facility is also hiring a wound care nurse. Resident #9 was admitted on 12/11/12 (not on 12/6/12) and was determined to have “soft and mushy heels with peeling skin” during the admission assessment. Preventative treatment was started on 12/13/12. The DON/ADON will review MAR’s and care plans monthly to ensure that anyone receiving Aranesp has a care plan in place. (4) Any instances of care plans not being initiated in a timely manner will be reported to the Administrator and will be discussed during the quarterly QA Meeting.	

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	On 1/29/13 the right heel was indicated as a Stage 3 and measured in centimeters (cm) as 1.2 x (by) 0.6 x 0.3 with slough in the open wound bed; no information was indicated for the left heel; On 2/5/13 the right heel was indicated as a Stage 3 and measured in cm as 1.0 x 0.5 x 1.1 with a decrease in the size; On 2/5/13 the left heel was indicated as a Stage 2 with no measurement and described as red with peeling skin; On 2/12/13 the right heel was indicated as a Stage 3 and measured in cm 4.0 x 6.0 with depth "varies;" the description of the skin problem indicated multiple areas of peeling skin and ulcerations with a black spot necrosis measuring in cm as 0.6 x 0.4 x (unclear) indicated; On 2/12/13 the left heel was indicated as Stage 1 with non-blanchable redness and flaky skin; On 2/19/13 the right heel was indicated as Stage 3 measuring in cm 6.0 x 7.0 with varying depth; the skin was described with continued redness and peeling skin with "black spot gone;" On 2/19/13 the left heel was indicated			

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	as a Stage 2 with no measurements indicated; the skin was described with cracked and peeling skin and no redness; On 2/26/13 the right heel was indicated as a Stage 3 and measured in cm 4.0 x 6.0 and varied depth; the skin was described with 2 "slit like" areas in the middle of the non-blanchable redness; On 2/26/13 the left heel was indicated as a Stage 1 with no measurement and no change indicated in the skin description; On 3/5/13 the right heel was indicated as a Stage 3 and measured in cm 4.0 x 6.0 with varying depth; the skin was described with continued "open areas within"; On 3/5/13 the left heel was indicated as a Stage 1 with no measurements and "non blanchable redness"; On 3/12/13 the right heel was indicated as a Stage 3 and measured in cm 6.5 x 7.5 with varying depth; the "tissue type" was indicated as eschar with the skin described as deep, cracked and bleeding; On 3/12/13 the left heel was indicated as a Stage 2 and measured in cm 6.5 x 7.5 with less than 0.1 depth; the "tissue type" was indicated as			

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	epithelial tissue with the skin described as cracked with peeling skin. The physician's visit notation, dated 1/10/13, indicated the resident's left heel was tender and callous posterior and lateral with a pressure sore on the right heel and to use "zero pressure" to both heels in bed. Resident #9's care plans included, but were not limited to, the following: The care plan, dated 12/21/12, was the potential for skin breakdown due to the resident's impaired mobility. The goal was to not have skin breakdown for the duration of her stay and/or the next 90 days. The interventions were skin check sheets with each shower, notify charge nurse of any broken areas of skin or skin issues; record skin assessment upon admission and weekly; report any deterioration in skin integrity to charge nurse and the physician; assist with turning and repositioning as needed. The undated intervention to "elevate bilat (bilateral) legs when in bed. FLOAT HEELS - NSG (nursing)" was added to the interventions with a physician's order to float heels written on 1/3/12 (sic).			

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	A care plan for the Stage 2 pressure ulcer on the left heel and the care plan for the Stage 3 pressure ulcer on the right heel were both initiated on 2/5/13. On 3/22/13 at 8:55 a.m., during an interview LPN #19, the designated wound nurse, indicated a care plan should had been initiated when Resident #9's heels were indicated as "soft and mushy." The "DECUBITUS ULCERS (PRESSURE SORES)" policy was provided by the DON (Director of Nursing) on 3/22/13 at 10:10 a.m. This current policy indicated the following: "PURPOSE: To assure that residents having pressure sores will receive necessary treatment to promote healing, prevent new sores from developing, and prevent infection. ...PROCEDURES: ...5. An entry is to be made on the resident careplan relative to skin condition. This entry should include location and stage. 6. Interventions to prevent further decubitus ulcer formation should be instituted."			

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	155389	A. BUILDING 00 B. WING	03/22/2013

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	The "PREVENTION OF DECUBITUS ULCERS (BEDSORES)" policy was provided by the Director of Nursing on 3/22/12 at 10:10 a.m. This current policy indicated the following: "...RECOGNIZING THE SIGNS/SYMPTOMS OF A PRESSURE SORE: 1. Usually the first signs of a bedsore forming on the resident's skin are: *Heat; *Reddened areas; *Tenderness; *A feeling of burning at the site; *Discomfort;...." 2.) Resident #9's record was reviewed on 3/21/13 at 9:45 a.m. The resident's diagnoses included, but were not limited to, anemia, coronary artery disease, hypertension, and CKD (Chronic Kidney Disease). The signed rewrite physician's order, dated 12/12/12, indicated the physician's order was Darbepoetin Alpha (Aranesp) 60 mcg (micrograms) inject subcutaneously 1 time a week. The physician order, dated 1/25/13, was Aranesp 40 mcg inject subcutaneously every month; hold if hemoglobin is greater than 10.			

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	During an interview on 3/21/13 at 2:00 p.m., RN #5 indicated the drug reference used by the nursing staff was "Davis's Drug Guide for Nurses TWELFTH EDITION." This reference indicated Darbepoetin (Aranesp) was classified as an "antianemics" and was indicated for anemia associated with chronic renal failure. The nursing implications indicated the following: Blood pressure should be monitored before and during therapy; Monitor response for symptoms of anemia [fatigue, dyspnea, pallor]; Hemoglobin should be monitored; Monitor as medication could increase the likelihood of life-threatening cardiovascular complication, cardiac arrest, neurologic events (seizures, stroke), hypertensive reactions,, CHF, vascular thrombosis/ischemia/infarction, acute MI , and fluid overload/edema. No care plan was indicated related to the use of Arenesp. 3.1-35(a)			

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F000282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation and record review the facility failed to ensure residents plans of care and physician orders were followed for 5 of 35 residents who met the CQLI [Criteria for Quality of Life and Care] related to physician orders and plans of care (Residents #32, 49, 20, 9 and 35). Findings include: 1. The record for Resident #32 was reviewed on 03-20-13 at 9:00 a.m. Diagnoses included but were not limited to dementia, history of breast cancer, hypertension, diabetes mellitus, depression and aphasia. These diagnoses remained current at the time of the record review. A plan of care originally dated 12-14-11, indicated the resident had the potential for further skin breakdown due to impaired mobility and incontinence. Interventions to this plan of care included positional devices as needed such as a pillow, chair cushions. Encourage repositioning in chair every 1-2 hours	F000282	Resident's with skin breakdown with the potential for further skin breakdown due to impaired mobility will have a pressure relieving cushion in their wheelchair.All resident's currently have pressure relieving mattresses. A new wheelchair has been ordered for resident # 49 to assist with proper positioning. Residents will continue to be checked every two hours and as needed for incontinent episodes. All of the referenced residents have no skin breakdown. All resident's receiving the medication Aransep will have a care plan related to its use. If telephone consent is obtained for ABN, a copy of the notice will be sent via mail with return receipt requested. The (1) receipt will be attached to the ABN notice for retention in the file. In regards to resident #35, the order to monitor weekly blood pressure and pulse was written on 3/21/13. There was no blood pressure and pulse recorded on 3/20/13 because the order had not yet been written. We will continue to monitor blood pressure and pulse as ordered by the physician. (2) MDS assessments will be reviewed to	04/16/2013

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	During continuous observations on 03-20-13 from 8:09 a.m. until 11:00 a.m., the resident was seated in the wheelchair. The resident did not have an anti-pressure device on the seat of the wheelchair. 2. The record for Resident #49 was reviewed on 03-20-13 at 9:00 a.m. Diagnoses included but were not limited to debility, cerebral vascular accident, hypertension, anemia, osteoarthritis, skin graft left arm, dysphasia, left hemiplegia and 2nd degree burns. These diagnoses remained current at the time of the record review. A plan of care, dated 01-17-13, indicated the resident had the "potential for skin breakdown due to impaired mobility, incontinence and diabetes." Interventions to this plan of care included "positional devices as needed such as pillows, chair cushions, Encourage repositioning in chair every 1 -2 hours." A plan of care originally dated 01-17-13 indicated the resident had dysphagia "due to late effects of cerebral vascular accident and at high risk for aspiration." Interventions to this plan of care included "have		ensure that residents with potential for skin breakdown due to impaired mobility have pressure relieving cushions in their wheelchairs. MAR's and care plans will be reviewed to ensure that any resident receiving Aranesp has a care plan related to its use. (3) Resident's with the potential for skin breakdown due to impaired mobility will have a pressure relieving cushion in their wheelchair. All resident's receiving Aranesp will have a care plan related to its use. If telephone consent has been obtained for ABN, an attempt will be made to obtain a signature by mailing a copy of the notice with return receipt requested. The DON/ADON will review skin sheets,treatments/preventative methods, and care plans weekly to ensure that proper care plans are in place and being followed. Medication records and care plans will be reviewed monthly to ensure that all resident's receiving Aranesp have a care plan related to its use. The Administrator will monitor the procedure with the ABN notices weekly at the Medicare Meeting.	

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	[name of resident] in upright position for all meals and keep [name of resident] in upright position at least 30 minutes after each meal or receiving liquids." During an observation on 03-19-13 at 7:50 a.m., the resident was seated in a reclining wheelchair on 03-19-13 at 7:50 a.m., in the assist dining room. The nursing staff provided the breakfast meal to the resident, and the resident remained in the reclined position. During continuous observation on 03-19-13 at 10:46 a.m., 10:52 a.m. and again at 1:05 p.m., the resident remained seated in the reclining wheelchair without a position change and without being positioned upright after meal service. During an observation on 03-20-13 at 8:09 a.m., the resident was seated in the wheelchair in the assist dining room. The resident was in a reclined position with a folded sheet place behind the resident's neck/head. At 8:52 a.m. the resident was moved to the TV lounge and at 9:10 a.m. moved to the resident's room. The resident remained in the reclining wheelchair without a position change at 11:20 a.m. The Certified Nurse Aide indicated she "got the resident up when she got to work in the			

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	morning around 7:00 a.m." During an observation in the assist dining room on 03-21-13 at 8:14 a.m., the resident was seated in the wheelchair in the reclined position. The resident was fed in the reclined position by the Certified Nurse Aide. Upon completion of breakfast the resident was transported back to the room and remained seated in the wheelchair without a change in position. At 10:24 a.m., the resident remained in same position. During an observation in the assist dining room on 03-21-13 at 12:40 p.m. the resident was fed by the QMA (Qualified Medication Aide) in a reclined position. During an observation on 03-21-13 at 1:30 p.m., Certified Nurse Aides #18 and #20 transferred the resident from the wheelchair to bed. During this observation the Certified Nurses Aide indicated it was the first time the resident had been laid down since she prepared the resident for breakfast. 3. The record for Resident #20 was reviewed on 03-19-13 at 8:00 a.m. Diagnoses included but were not limited to mixed dementia, seizure			

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	disorder, diabetes mellitus, and hypertension. These diagnoses remained current at the time of the record review. Review of the resident's minimum data set assessment, dated 02-14-13, indicated the resident was "always incontinent of bowel and bladder." The resident's current plan of care, originally dated 11-23-12, indicated the resident had a self care deficit requiring prompts and cues - total to extensive assist for hygiene and toileting. On 03-18-13 at 10:15 a.m., the resident was observed seated in the resident's room. Upon entrance to the room, by permission of the resident, a strong urine odor permeated the air. The resident's sweat pants were soaked with moisture across the front and upper legs of the pants. The resident indicated, "I think I [expletive for urination]." The nursing staff was informed of the resident's incontinent episode. During an observation on 03-21-13 at 1:00 p.m., there was a distinct urine odor as the resident passed through the dining room. Certified Nurse Aide			

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	(CNA) #18 was questioned about the resident's incontinence, and the certified nurses aide indicated the resident was not incontinent. A request was made to check the resident for incontinence. During an interview on 03-21-13 at 1:30 p.m., the CNA indicated the resident was wet, "it was just pee, [resident] urine is very strong." 4. Resident #9's record was reviewed on 3/21/13 at 9:45 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, hypertension, Diabetic Mellitus Type II and CKD (Chronic Kidney Disease). The signed rewrite physician's order, dated 12/12/12, indicated the physician's order was Darbepoetin Alpha (Aranesp) (antianemic) 60 mcg (micrograms) inject subcutaneously 1 time a week. A physician order, dated 1/25/13, indicated. " Aranesp 40 mcg (micrograms)inject subcutaneously (under the skin) every month; hold if hemoglobin is greater than 10." A physician order, dated 2/28/13, indicated, "Aranesp 40 mcg inject subcutaneously every month starting			

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	on 2/28/13." The Medication Administration Record indicated the following: On 12/19/12, Aranesp was not given. The record indicated the Hemoglobin was 10.7 but did not include a physician's order for omission related to a Hemoglobin laboratory (lab) test result on that date. On 1/31/13 Aranesp was not given. The record did not indicate a reason the medication was not given. A Hemoglobin lab result, dated 1/14/13, indicated a low result of 9.9, indicating the medication should have been given (per the 1/25/13 physician's order). On 2/28/13 Aranesp was no given. The record indicated the medication was not available. The Hemoglobin lab result, dated 2/28/12, was 9.7 (low), indicating the medication should have been given (per the 1/25/13 physician's order). On 3/22/13 at 10:25 a.m., during an interview, the Director of Nursing (DON) indicated there was no hold order related to the hemoglobin for the medication, Aranesp, prior to the 1/25/13 physician's order.			

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	On 3/22/13 at 3:25 p.m., during an interview, the DON indicated the pharmacy did not always send the medication, Arenesp, until the pharmacy reviewed the hemoglobin. Based on record review and interview, the facility failed to ensure a telephone consent for ABN (Advance Beneficiary Notice of Noncoverage) was followed up with an attempt to obtain the resident's responsible party's signature for 1 of 1 telephone consent in a sample of 3 notices of non-coverage reviews. (Resident #36) Findings included: Resident #36's notice for Medicare non-coverage was reviewed on 3/21/2013. This record indicated the resident on 10/15/12 "refused to sign, wasn't understanding the notice..." This same record also indicated the resident's responsible party was notified via telephone on this same day (10/15/12), and a phone consent was obtained. On 3/22/2013 at 9:15 a.m., during an			

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	interview, the Social Service Director indicated she did a phone approval on 10/15/12 but did not follow up with a signed consent. The "DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services Second Edition," dated April 2011, indicated the following related to ABN's: "...When delivery is not in-person, the contact must be documented in the beneficiary's records. To be considered effective, the beneficiary cannot dispute such contact. Telephone contacts must be followed immediately by either a hand-delivered, mailed, e-mailed, or faxed notice. The beneficiary or representative must sign and retain the notice and send a copy of this signed notice to the health care provider for retention in the beneficiary's record. The provider/supplier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the health care provider must document the initial contact and subsequent attempts to obtain a signature in appropriate			

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	records or on the notice itself...." 3.1-4(f)(3) During an observation on 03/21/2013 at 10:00 a.m., Resident #35 was observed in his room watching television. The resident indicated he was "sleepy." Resident #35's record was reviewed on 03/21/13 at 10:15 a.m. Diagnoses included, but were not limited to, diabetes mellitus and hypertension (high blood pressure). A care plan, dated 11/06/2012, indicated, ",,,monitor VS (vital signs)...." A physician's order, dated 03/21/13, indicated blood pressure and pulse should have been monitored weekly on Wednesdays. A treatment flow sheet indicated the			

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	blood pressure was not monitored on Wednesday, 03/20/2013. 3.1-35(g)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observations, interview, and record review, the facility failed to assess and evaluate a dialysis resident upon return to the facility for 1 of 1 resident reviewed for dialysis (Resident #127) in a sample of 3 dialysis residents and failed to ensure positioning for 2 of 3 residents reviewed for positioning in a sample of 30 (Residents #32 and #49). Findings include: 1. The record for Resident #32 was reviewed on 03-20-13 at 9:00 a.m. Diagnoses included but were not limited to dementia, history of breast cancer, hypertension, diabetes mellitus, depression and aphasia. These diagnoses remained current at the time of the record review. A plan of care originally dated 12-14-11, indicated the resident had the potential for further skin breakdown due to impaired mobility and incontinence. Interventions to	F000309	(1) For all dialysis patients the dialysis port dressing will be assessed each shift for placement, blood, and/or drainage. The patient will be assessed for pain. This will be documented on the MAR. Upon return from dialysis the patient and port site will be assessed as well. These assessments will be documented on the medical record. This was being done before, but was not being documented properly. Resident #32 has a pressure relieving cushion in her wheelchair. A new wheelchair to assist in positioning has been ordered for resident # 49. (2) Resident's MDS assessments will be reviewed to identify other resident's with the potential to be affected. (3) All residents with the potential for further skin breakdown as a result of impaired mobility will have a pressure relieving cushion in their wheelchair. All dialysis patients will have their port site dressing assessed each shift and upon return from dialysis. The patient will be assessed for pain/discomfort each shift and	04/16/2013

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	this plan of care included positional devices as needed such as a pillow, chair cushions. Encourage repositioning in chair every 1-2 hours During continuous observations on 03-20-13 from 8:09 a.m. until 11:00 a.m., the resident was seated in the wheelchair. The resident did not have an anti-pressure device on the seat of the wheelchair. 2. The record for Resident #49 was reviewed on 03-20-13 at 9:00 a.m. Diagnoses included but were not limited to debility, cerebral vascular accident, hypertension, anemia, osteoarthritis, skin graft left arm, dysphasia, left hemiplegia and 2nd degree burns. These diagnoses remained current at the time of the record review. A plan of care, dated 01-17-13, indicated the resident had the "potential for skin breakdown due to impaired mobility, incontinence and diabetes." Interventions to this plan of care included "positional devices as needed such as pillows, chair cushions, Encourage repositioning in chair every 1 -2 hours." A plan of care, originally dated 01-17-13, indicated the resident had		upon return from dialysis. (4) The DON/ADON will review documentation for dialysis patients on every dialysis day for one week, then once a week for one week, and after that monthly. The DON/ADON will review care plans monthly to ensure that residents with the potential for further skin breakdown due to impaired mobility have pressure relieving cushions in their wheelchairs.	

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	dysphagia "due to late effects of cerebral vascular accident and at high risk for aspiration." Interventions to this plan of care included "have [name of resident] in upright position for all meals and keep [name of resident] in upright position at least 30 minutes after each meal or receiving liquids." During an observation on 03-19-13 at 7:50 a.m., the resident was seated in a reclining wheelchair on 03-19-13 at 7:50 a.m., in the assist dining room. The nursing staff provided the breakfast meal to the resident, and the resident remained in the reclined position. During continuous observation on 03-19-13 at 10:46 a.m., 10:52 a.m. and again at 1:05 p.m., the resident remained seated in the reclining wheelchair without a position change and without being positioned upright after meal service. During an observation on 03-20-13 at 8:09 a.m., the resident was seated in the wheelchair in the assist dining room. The resident was in a reclined position with a folded sheet placed behind the resident's neck/head. At 8:52 a.m. the resident was moved to the TV lounge and at 9:10 a.m. moved to the resident's room. The resident remained in the reclining			

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	wheelchair without a position change at 11:20 a.m. The Certified Nurse Aide indicated she "got the resident up when she got to work in the morning around 7:00 a.m." During an observation in the assist dining room on 03-21-13 at 8:14 a.m., the resident was seated in the wheelchair in the reclined position. The resident was fed in the reclined position by the Certified Nurse Aide. Upon completion of breakfast the resident was transported back to the room and remained seated in the wheelchair without a change in position. At 10:24 a.m., the resident remained in same position. During an observation in the assist dining room on 03-21-13 at 12:40 p.m. the resident was fed by the QMA (Qualified Medication Aide) in a reclined position. A sheet was observed rolled up and placed behind the resident's head. The residents right leg was observed off of the foot rest and dangling to the side of the wheelchair. At 1:10 p.m. the resident remained in wheelchair. The resident's right arm/hand dangled to the right side of the wheelchair. The resident's neck was hyperextended and a sheet was folded and placed behind the resident's head.			

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	During an observation on 03-21-13 at 1:30 p.m., two Certified Nurse Aides transferred the resident from the wheelchair to bed. During this observation the Certified Nurse Aide indicated it was the first time the resident had been laid down since she prepared the resident for breakfast in the morning. 3. On 3/20/13 at 9:01 a.m., during an interview RN #5 indicated Resident #127's scheduled dialysis was on Monday, Wednesday and Friday of each week. She indicated the resident's right upper forearm fistula was not cleared to use, and she had a permanent catheter located in her left claviclular area for use at dialysis. On 3/20/13 at 9:36 a.m., during an interview, RN #12 indicated if the access site was examined and indicated the information would have been indicated in the nurses notes. On 3/2013 at 9:40 a.m., during an interview, RN #5 indicated the assessment of the dialysis site should have been documented in the nurse's notes as flow records were not used. On 3/21/13 at 9:50 a.m., during an interview, the Director of Nursing indicated if there was an			

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	order/direction to assess the resident's dialysis access site, the information should have been documented in the nurses notes. Resident #127's record was reviewed on 3/21/13 at 9:50 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease. The nurse's notes from 3/8/13 at 6 p.m. to 3/20/13 at 11:00 a.m. lacked documentation to indicate the dialysis access site was assessed on 3/8/13, 3/9/13, 3/10, 13, 3/12/13, 3/15/13, 3/16/13, 3/17/13, and 3/19/13. The policy for monitoring a resident's dialysis port was provided by the Director of Nursing on 3/21/13 at 2:30 p.m. This current policy indicated the following: "It is the policy of Westpark Healthcare to monitor the Dialysis Port dressing for dialysis patients each shift....." 3.1-37(a)			

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F000314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review, observation, and interview, the facility failed to ensure pressure areas were assessed and monitored timely with alternative preventive measures implemented and incontinent care provided to prevent potential skin breakdown to a resident observed in moisture saturated clothing for 4 of 7 residents reviewed for pressure ulcers. (Resident #9, #21, #53, and #49) Findings include: 1. Resident #9's record was reviewed on 3/21/13 at 9:45 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, hypertension, and Diabetic Mellitus Type II. The resident was discharged on 3/19/13.	F000314	(1)The DON/ADON will review the affected resident's skin sheets and treatments to determine if the skin condition is being treated appropriately. The DON/ADON will also assess and measure any current wounds and ensure that measurements on the skin sheets are accurate. The DON/ADON will do rounds to ensure that appropriate preventative measures are being completed as ordered. The DON/ADON will also do rounds to ensure that appropriate incontinent care is being provided. (2) The DON/ADON will complete skin checks on each current resident to ensure that the current skin sheets are accurate and the treatments appropriate, in order to identify any other residents that could potentially be affected. (3) A new wound care nurse is being hired. A wound care team consisting of the Administrator, Asst. Administrator, DON,	04/16/2013

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	The "NORTON PLUS PRESSURE ULCER SCALE," dated 12/11/12, indicated the total score was 16 with a total score of 10 or less equaled a high risk. The "TOTAL NUMBER OF CHECK MARKS" of "3" was to be deducted from the "NORTON SCALE SCORE" of 16 resulting in an actual total score of 13, not 16. No further information was indicated on this record. The admission "Skin Check" record, dated 12/6/12, indicated on a body diagram the resident's bilateral heels were "soft & mushy" with skin peeling off of her left heel. The "PRESSURE ULCER REPORT AND OTHER SKIN CONDITION REPORT" record indicated the following related to the resident's heels: The first documentation related to the resident's heels was on 1/15/13 where both heels were indicated as red with peeling skin with no measurements included; On 1/22/13 both heels were indicated as having decreased redness but continued with areas of peeling skin and no measurements included;		ADON,Wound Nurse, and Medical Director has also been established and will be doing weekly wound rounds. Within 24 hours of admission the DON/ADON or wound nurse will be reviewing new admission skin sheets and ensuring that they are accurate and have appropriate treatments/preventative measures ordered. (4) The wound care team will be doing rounds weekly in order to ensure that wounds are being properly documented and treated.Results of the rounds will be discussed quarterly in QA. The DON/ADON/Evening Shift Supervisor will do rounds every two hours for two weeks during day shift/evening shift. The Night Shift Supervisor will do rounds during night shift every two hours for two weeks to ensure that positioning of residents and incontinent care are being done every two hours and as needed. After the initial two weeks the supervisor on each shift will do a randomly timed round on each shift indefinitely. During these rounds, preventative measures,such as floating heels will also be checked to ensure that they are being done.	

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	On 1/29/13 the right heel was indicated as a Stage 3 and measured in centimeters (cm) as 1.2 x (by) 0.6 x 0.3 with slough in the open wound bed; no information was indicated for the left heel; On 2/5/13 the right heel was indicated as a Stage 3 and measured in cm as 1.0 x 0.5 x 1.1 with a decrease in the size; On 2/5/13 the left heel was indicated as a Stage 2 with no measurement and described as red with peeling skin; On 2/12/13 the right heel was indicated as a Stage 3 and measured in cm 4.0 x 6.0 with depth "varies;" the description of the skin problem indicated multiple areas of peeling skin and ulcerations with a black spot necrosis measuring in cm as 0.6 x 0.4 x (unclear) indicated; On 2/12/13 the left heel was indicated as Stage 1 with non-blanchable redness and flaky skin; On 2/19/13 the right heel was indicated as Stage 3 measuring in cm 6.0 x 7.0 with varying depth; the skin was described with continued redness and peeling skin with "black spot gone;" On 2/19/13 the left heel was indicated			

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	as a Stage 2 with no measurements indicated; the skin was described with cracked and peeling skin and no redness; On 2/26/13 the right heel was indicated as a Stage 3 and measured in cm 4.0 x 6.0 and varied depth; the skin was described with 2 "slit like" areas in the middle of the non-blanchable redness; On 2/26/13 the left heel was indicated as a Stage 1 with no measurement and no change indicated in the skin description; On 3/5/13 the right heel was indicated as a Stage 3 and measured in cm 4.0 x 6.0 with varying depth; the skin was described with continued "open areas within"; On 3/5/13 the left heel was indicated as a Stage 1 with no measurements and "non blanchable redness"; On 3/12/13 the right heel was indicated as a Stage 3 and measured in cm 6.5 x 7.5 with varying depth; the "tissue type" was indicated as eschar with the skin described as deep, cracked and bleeding; On 3/12/13 the left heel was indicated as a Stage 2 and measured in cm 6.5 x 7.5 with less than 0.1 depth; the "tissue type" was indicated as			

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	epithelial tissue with the skin described as cracked with peeling skin. No further information of the resident's heels was indicated in the nurse's notes related to the resident's skin condition from 12/7/12 to 3/21/13. The physician's visit notation, dated 1/10/13, indicated the resident's left heel was tender and callous posterior and lateral with a pressure sore on the right heel and to use "zero pressure" to both heels in bed. The admission Minimum Data Set assessment, dated 12/18/12, indicated the resident's Basic Interview Mental Status's score was 11 with a score of 8 to 15 as interviewable. The resident was at risk for skin breakdown with no unhealed pressure ulcers indicated and with a diabetic foot ulcer. The physician's orders were as follows: On 12/13/12 the order was to wash BLE (bilateral lower extremities) with mild soap and water, pat dry and apply Vasolex to skin including heels and wrap with kerlix and change every day; On 12/27/12 the order was to clean			

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	BLE with soap and water, pat dry and apply Vasolex to left leg and foot bid (2 times a day) and leave open to air; cover the right leg and foot in its entirety with Vasolex , cover 2 open area with gauze and wrap with kerlex bid and prn (as needed); On 1/3/13 the order was to continue Vasolex orders to BLE and elevate bilateral legs when in bed "FLOAT HEELS"; On 1/10/13 the order was "zero pressure" to bilateral heels while in bed - off load with pillows; On 1/28/13 the order was to cleanse BLE with mild soap and water, Vasolex or an equivalent to open areas and telfa, kerlix every day; On 1/30/13 the order was to discontinue (d/c) the Vasolex to the right heel bid and prn; clean open area of the right heel with normal saline, apply santyl to wound bed, cover with gauge and wrap with kerlex; change daily and prn; d/c telfa and kerlex to BLE - continue with the Vasolex; On 2/6/13 the order was to d/c the orders to elevate heels; d/c previous treatment to the right heel; start: apply Vasolex to bilateral heels and cover with gauze and wrap with kerlex and change bid; elevate BLE on 2 pillows at all times when in bed and hang heels over the edge of pillows;			

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	On 2/25/13 the order was to apply Vasolex to left foot and leg; cover with gauze and loosely wrap with kerlex; apply Vasolex to right foot and leg bid; On 3/1/13 the order was to d/c treatment to right foot and leg; start: wash right leg and foot with soap and water; apply Santyl to open areas and Vasolex to remainder of foot and heel, cover with gauze and wrap with kerlex, change daily; On 3/8/13 the order was a left foot crowe boot and a right foot diabetic shoe; On 3/18/13 the order was to d/c all previous treatment orders; apply thick layer of Vasolex to left heel; wash right leg and foot with soap and water, apply Santyl to the 3 open areas on heel, apply Vasolex to remainder of right foot and heel, cover with gauze and wrap with kerlex. On 3/21/13 at 8:15 a.m., during an interview LPN #19 indicated she did the wound dressings throughout the week and stated she "was a phone call away" on the weekends. She indicated the evening nurse provided the wound care on weekends. On 3/21/12 at 2:20 p.m., during an interview, RN #5 indicated Resident			

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	#9 was not very compliant in keeping her heels off of the bed when she was in bed. RN #5 also indicated she had special shoes and thought those shoes contributed to the resident's heels breakdown. On 3/22/13 at 8:55 a.m., during an interview LPN #19 indicated wound measurements should have been done weekly. She also indicated with soft and mushy heels a preventive measure would have been to keep the resident's heels off of the bed. She indicated Resident #9 would not keep pillows in place to keep her heels off of the bed with her short term memory, so a gel pillow was tried. The resident complained the gel pillow limited her movement too much in bed, so the gel pillow was no longer used. LPN #19 indicated the resident did have waffle boots from the hospital, but she would not keep them on. LPN #19 indicated, with soft and mushy heels, the resident's heels would have been floated initially, and then Vasolex would have been used. 2. The record for Resident #53 was reviewed on 03-22-13 at 10:00 a.m. Diagnoses included, but were not limited to, cognitive deficits, psychosis, hypotension, loss of weight, cerebrovascular disease,			

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	vascular dementia, hypertension, and history of urinary tract infection. These diagnoses remained current at the time of the record review. Review of the Norton plus pressure ulcer scale, dated 10-11-12, indicated the resident had a score of "14" with fair physical condition, alert mental state, walked with help, mobility slightly limited and occasionally incontinent. The assessment indicated a score of 10 or greater identified the resident at high risk for pressure ulcers. The Norton plus pressure ulcer scale assessment, dated 01-11-13, indicated the resident's score was "8" and had fair physical condition, confused mental state, chair bound, mobility very limited and had double incontinence. The Norton plus pressure ulcer scale assessment, dated 02-21-13, indicated the resident's score was "7" and had poor physical condition, was confused, chairbound, very limited mobility and double incontinence. Review of the resident's current plan of care, dated 02-18-13, indicated the resident required assist from staff with turning and repositioning due to			

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	impaired mobility. Interventions included "observe skin daily and record/report any new broken areas, report any deterioration in skin integrity to charge nurse and physician." Review of the facility "pressure ulcer report and other skin condition report," from 10-23-12 thru 02-05-12 indicated the resident did not have any "open areas." A notation on 02-14-13 indicated the resident now had an area which measured 6.5 centimeters by 4.2 centimeters by 0.2 centimeters, "slough - non blanchable, redness with 3 open areas with slough." The record lacked information the plan of care was followed for notification of the resident's change in status until the area was not only red with 3 open areas, and measurements as noted above. Physician orders, dated 02-14-13 instructed the nursing staff to apply santyl ointment topically to buttocks, gluteal fold, slough after cleaning, gauze, and tegaderm daily and prn [as needed] dislodgement. Sodium chloride 0.9 % 250 c.c. [cubic centimeters] irrigation, cleanse buttock and gluteal fold wound once a			

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	day and prn dislodgement. During observation on 03-22-13 at 1:44 p.m., and with the Director of Nurses in attendance, the wound on the buttocks was measured. Measurements included 4.0 centimeters width by 6.6 centimeters in length with 3.0 centimeters red wound margins around the wound. There was yellow drainage with slight serosanguinious blood noted during the observation. 3. The record for Resident #49 was review on 03-20-13 at 9:00 a.m. Diagnoses included, but were not limited to, debility, cerebral vascular accident, hypertension, anemia, osteoarthritis, skin graft left arm, dysphasia, left hemiplegia and 2nd degree burns. These diagnoses remained current at the time of the record review. Review of the plan of care, dated 01-17-13, indicated the resident had the potential for skin breakdown due to impaired mobility, incontinence and diabetes. Interventions to this plan of care included "positional devices as needed such as pillows, chair cushions, Encourage repositioning in chair every 1 -2 hours."			

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	The resident scored 9/16 on the Braden Risk assessment scale which indicated the resident was at a high risk for developing pressure ulcers. During observations on 03-19-13 at 7:50 a.m., in the assist dining room, the resident was seated in a reclining wheelchair. The nursing staff provided the breakfast meal to the resident while the resident remained in the reclined position. During continued observations on 03-19-13 at 10:46 a.m., 10:52 a.m. and 1:05 p.m., the resident remained seated in the reclining wheelchair without a position change. During an observation on 03-20-13 at 8:09 a.m., the resident was seated in the wheelchair in the assist dining room. The resident was in a reclined position with a sheet folded and placed behind the resident's neck/head. At 8:52 a.m. the resident was moved to the TV lounge and at 9:10 a.m. moved to the resident's room. The resident was not repositioned in the wheelchair during these observations. During an observation on 03-20-12 at 11:20 a.m., a request was made to check the resident for incontinence. The MDS Coordinator checked the			

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	resident and indicated the resident was incontinent. During this observation, the Certified Nurse Aide stated "I got the resident up when I got to work in the morning around 7:00 a.m." Observation on 03-21-13 at 8:14 a.m., the resident was observed seated in the wheelchair in the assist dining room in a reclined position. Upon completion of breakfast the resident was transported back to the room and remained seated in the wheelchair. At 10:24 a.m., the resident remained in room, in same position. At 12:40 p.m. the resident was observed in assist dining room, being fed by the QMA (qualified medication aide) in a reclined position. A sheet was observed rolled up and placed behind the resident's head. The residents right leg was observed off of the foot rest and dangling to the side of the wheelchair. At 1:10 p.m. the resident remained in wheelchair. The resident's right arm/hand dangled to the right side of the wheelchair. The resident's neck was hyperextended and a sheet was folded and placed behind the resident's head. At 1:30 p.m., Certified Nurses Aides # 18 and #20 prepared to transfer the resident from			

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	the wheelchair to bed. Upon removal of the resident's incontinent brief the resident bilateral buttocks and rectal area were bright red in color. During this observation the Certified Nurse Aide indicated it was the first time the resident had been laid down since breakfast. 4. On 3/20/13 at 9:39 a.m., Resident #21's personal care was observed in bed. CNA #25 and unidentified CNA cleansed the resident's private area and applied an incontinence brief without applying protective cream to the resident's buttocks. On 3/22/13 at 9:05 a.m., Resident #21 was observed with his eyes closed, lying on his back in bed. Both feet were elevated utilizing 2 pillows. The resident's heels rested on the pillows (not floated) with the bottom of the resident's feet touching the footboard of the bed. The right heel was observed with the skin intact. At this same time, during an interview, LPN #9 indicated the resident was on a standard pressure reducing mattress used throughout the facility. Resident #21's record was reviewed on 3/20/13 at 8:43 a.m. The resident's diagnoses included, but were not limited to, dysphagia, malignant neoplasm of prostate,			

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	anemia in CKD (chronic kidney disease), and CHF (congestive heart failure). The quarterly Minimum Data Set assessment, dated 12/26/12, indicated the resident required extensive assistance of 1 to 2 persons for mobility and activities of daily living. The BIMS (brief interview for mental status) score was 14 with a score of 8 to 15 as interviewable. The care plans indicated the following: Care plan, initially dated 9/21/12, indicated a "Stage 2 Pressure Ulcer on His Sacrum" was healed (with no date indicated). The interventions included, but were not limited to, "Anti-pressure device: Low air loss mattress on bed; consult with MD as needed for interventions and treatment for area; use positional devices (e.g. pillows) to keep boney prominences from direct contact with one another." Care plan, initially dated 10/1/12, indicated "Potential for skin breakdown due to impaired mobility and incontinence." The goal was to have no skin breakdown through the duration of stay/next 90 days. The interventions included, but were not limited to, "Vaseline to buttocks and			

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	scrotum every shift and prn (as needed); bilat (bilateral) legs to be elevated on 2 pillows at all times when in bed." Care plan, initially dated 12/7/12, indicated a Stage 4 (pressure ulcer) on the right heel, which was indicated as healed on 2/19/13. The interventions included, but were not limited to, "Elevate R (right) leg on 2 pillows at all times while in bed to float heel". A care plan was initiated on 1/16/13 for a stage 2 pressure ulcer on R anterior ankle, which was indicated as healed (with no date indicated). A care plan was initiated 3/7/13 for a stage 2 pressure ulcer on R inner buttock, which was indicated as healed on 3/18/13. During an interview on 3/22/13 at 11:15 a.m., LPN #19 (nurse who provided wound care) indicated Resident #21 should have had a longer bed. She indicated low air loss mattresses were used when a resident had a pressure ulcer or was placed on hospice services. She also indicated Vasoline was used as a skin protectant to prevent skin issues. The LPN indicated Resident #21			

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	should have had Vaseline applied as a preventative measure. The "PRIMARY RISK ASSESSMENT FOR PRESSURE ULCER DEVELOPMENT" policy was provided by the Director of Nursing (DON) on 3/22/13 at 10:10 a.m. This current policy indicated the following: "PURPOSE: To assess, upon admission, each resident for primary risk factors that could contribute to pressure ulcer development and implement interventions accordingly. POLICY: The Norton Scale will be completed by a licensed nurse when a resident is admitted to the facility. It will also be done every week for four (4) weeks following admission, and quarterly thereafter. Based upon the factors listed on this assessment, preventative measures shall be implemented accordingly. PROCEDURE: ...4. The Norton Scale shall be completed weekly for four weeks after admission, quarterly thereafter, and/or with significant change in condition."			

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	The "DECUBITUS ULCERS (PRESSURE SORES)" policy was provided by the DON on 3/22/13 at 10:10 a.m. This current policy indicated the following: "PURPOSE: To assure that residents having pressure sores will receive necessary treatment to promote healing, prevent new sores from developing, and prevent infection. ...PROCEDURES: 1. A licensed nurse will assess each resident for decubiti upon admission. 2. Each decubiti will be documented on the appropriate facility form. 3. Treatment orders will be obtained. Orders will be reviewed periodically for efficacy. 4. Ongoing measurements shall be obtained by a designated, qualified person. 5. An entry is to be made on the resident careplan relative to skin condition. This entry should include location and stage. 6. Interventions to prevent further decubitus ulcer formation should be instituted." The "PREVENTION OF DECUBITUS ULCERS (BEDSORES)" policy was provided by the DON on 3/22/13 at			

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	10:10 a.m. This current policy indicated the following: "...RECOGNIZING THE SIGNS/SYMPTOMS OF A PRESSURE SORE: 1. Usually the first signs of a bedsore forming on the resident's skin are: *Heat; *Reddened areas; *Tenderness; *A feeling of burning at the site; *Discomfort...." 3.1-40(a)(1) 3.1-40(a)(2)			

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure a clean and sanitary kitchen related to cleaning and handling of food preparation equipment for 1 of 1 kitchen observed. Findings include: During observation of kitchen procedures on 3/20/13 at 10:50 a.m., DA (Dietary Aide) #10 pureed barbeque chicken. The DA indicated the machine used to puree the chicken would be washed before the spinach was pureed spinach. DA #10 retrieved a used towel from the counter and used it to wipe a small amount of water out of the machine. DA #18 witnessed the towel from the counter being used to wipe the inside of the container and stated to DA #10, "you shouldn't have done that". DA #10 pureed the spinach without re-cleaning the equipment. During observation of kitchen	F000371	(1) A separate piece of equipment (bowl, lid, blade)will be used with the robot coupe for each individual food item/group when pureeing. All equipment used will be washed and air dried at the end of the process. This ensures there is no cross contamination between food items, and there is no wait time while allowing the equipment to air dry. This could have affected two residents receiving a pureed diet. Our policy states that all utensils/equipment are to be air dried after use before being stored. Staff will be reminded and in-serviced that no piece of equipment is to be towel dried. The RD and/or the DSM will monitor this daily for five days, twice a week for the remainder of the month, and then quarterly. (2) Our policy is that all hand towels are to be in buckets when not in use. Our policy is that all cutting boards are cleaned and sanitized between each use. This could have affected on average 10% of residents who order grilled cheese sandwiches. We will institute a new procedure for the handling/cutting of	04/16/2013

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	procedure on 3/20/13 at 11:10 a.m., DA # 10 was observed to pick up two hand towels, a spatula and another unidentified utensil from the counter in front of the warming area and set them on top of a cutting board. The DA #10 did not clean the cutting board surface before placing three grilled cheese sandwiches on the cutting board. The sandwiches were placed in individual bags for this lunch service. During an interview on 3/20/13 at 11:15 a.m., RD #7 (registered dietician) indicated dishes should be air dried prior to use. The "Storing Utensils, Tableware, and Equipment Policy " was provided by the RD #7 on 3/20/13 at 12:50 p.m. This current policy indicated the following: " Procedure: 1. Make sure all utensils, tableware, equipment are air dried before removing from drying rack and putting away. Do not use towels to dry equipment, etc. ...5. Cleaned and sanitized equipment and utensils should be		sandwiches; all sandwiches will be cut on the plate that it will be served on. Staff will be in-serviced and reminded of issues with cross contamination. The RD and/or the DSM will monitor this daily for five days, twice a week for the remainder of the month, and then quarterly.	

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	handled in a way that protects them from contamination. Utensils should only be touched by their handles. Cups, glasses, bowls, plates and similar items should be handled as as (sic) not to touch any surface that may come into contact with food or a resident's mouth". " Dishwashing: Machine " policy indicated the following: " ...f. Use clean, washed hands to pull out clean racks, and allow to air dry before putting dishes away for storage .... " During an interview with RD # 7 on 3/20/13 at approximately 11:15 a.m. she indicated dishes should be air dried prior to use. 3.1-21(i)(1)			

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F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review and interview, the facility failed to ensure the dispositon of resident's pain medications, which were being given	F000431	(1) All nurses will be in-serviced on proper documentation regarding PRN medications. It is our policy to document any PRN medication given and to also	04/16/2013

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	as needed (prn), were dispensed in a manner to track the administration and effectiveness of the medication for 5 of 7 residents randomly reviewed for the disposition of prn pain medications (Resident #128, #51, #17, #56, or #117). Findings include: 1. Resident #128's record was reviewed on 3/21/13 at 2:00 p.m. The resident's diagnoses included, but were not limited to, right shoulder osteoarthritis with arthroplasty, osteoarthritis, coronary artery disease, and Diabetic Mellitus Type II. The physician's order, dated 3/12/13, was Oxycodone IR (immediate release) (opoid analgesic for pain -scheduled III controlled substance) 2.5 milligrams (mg) by mouth (po) every (q) 8 hours (hrs) as need (prn) for pain. The physician's order, dated 3/13/13, was to increase the Oxycodone IR to 5 mg po q 4 hrs prn for pain. The "Controlled Substances Record" for Resident #128's Oxycodone 5 mg tablet give 1/2 tablet (2.5 mg) orally q 8 hrs prn for pain. This record indicated the following: On 3/13/13 one 1/2 tablet was		document its effectiveness. (2) The DON/ADON will review current resident's PRN medications to ensure correct documentation is being done. (3) The Unit Manager, DON and ADON will check the PRN medication record for proper documentation for each resident each shift for one week, one time a day on random shifts for one week, and monthly thereafter.Nurses found to be documenting incorrectly will be counseled and in-serviced. (4)Facility management will discuss the results of the documentation checks at QA.	

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	dispensed at 8:15 a.m.; On 3/13/13 two 1/2 tablets were dispensed at 11:40 a.m. and at 10:40 p.m.; On 3/16/13 two 1/2 tablets were dispensed at 9:00 p.m.; On 3/17/13 two 1/2 tablets were dispensed at 4:00 a.m. The Medication Administration Record for 3/2013 did not indicate Oxycodone was administered to the resident. The nurse's notes indicated the following: On 3/13/13 at 7:55 a.m. the resident was resting quietly without complaints. At 9:30 a.m. the resident had complained of increased pain to his right shoulder. At 11:30 a.m. the resident was complianing of pain in his right shoulder with the prn pain medication not effective, and the physician was notified. On 3/16/13 and 3/17/13 no information indicated the resident was complaining of pain. On 3/21/13 at 2:55 p.m., during an interview the Director of Nursing (DON) indicated she was unaware if the prn medication, Hydrocodone, had been given with no information indicated in the resident's record.			

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	On 3/22/13 at 1:43 p.m., during an interview Resident #128 indicated he was unsure if he had received a pain medication or not. He indicated they would bring all of his pills together in a cup, and he would take them. He indicated he did not recall asking for any pain medication recently. 2. Resident #56's record was reviewed on 3/21/13 at 3:00 p.m. The resident's diagnoses included, but were not limited to, chronic pain and chronic obstructive pulmonary disease. The physician's order, dated 11/21/12, was Vicoden 5/325 mg (milligrams) 1 tablet every 6 hours as needed for pain. The "Controlled Substances Record" for Resident #56's Hydrocodone-APAP (Vicodon) 5-325 mg tablet give 1 tablet orally q 6 hrs prn for pain. This record indicated the following: On 11/22/12 one tablet was dispensed at 5 a.m. and 9 p.m.; On 11/23/12 one tablet was dispensed at 12 a.m., 6 a.m., and 5:15 p.m.; On 11/24/12 one tablet was dispensed at 1:50 a.m., 6 a.m., and			

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	12 p.m.; On 11/25/12 one tablet was dispensed at 6 p.m.; On 11/26/12 one tablet was dispensed at 1 p.m.; On 11/27/12 one tablet was dispensed at 1:30 a.m., 6 a.m., 12:30 (a.m./p.m. not indicated), and 7:30 p.m.; On 11/28/12 one tablet was dispensed at 1:30 a.m., 6:30 a.m., 12:30 p.m., and 7:30 p.m.; On 11/29/12 one tablet was dispensed at 7:30 a.m., 2:15 p.m., and 9 p.m.; On 11/30/12 one tablet was dispensed at 5 a.m. and 6:30 p.m.; On 12/1/12 one tablet was dispensed at at 12 a.m., 6 a.m., 12:30 p.m., and 6 p.m.; On 12/2/12 one tablet was dispensed at 12 a.m., 6 a.m., 12:15 p.m., 4:15 p.m. and 8:30 p.m.; On 12/3/12 one tablet was dispensed at 12:30 a.m., 4:30 a.m., 12 p.m., and 6 p.m.; On 12/4/12 one tablet was dispensed at 3 a.m. and 5:30 p.m.; On 12/5/12 one tablet was dispensed at 2 a.m.; On 12/6/12 one tablet was dispensed at 2:45 a.m., 9:45 (a.m./p.m. not designated), 2:40 p.m., and 8:45 p.m.; On 12/7/12 one tablet was dispensed			

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	at 2 a.m., 8:20 a.m., and 2:20 p.m.; On 12/8/12 one tablet was dispensed at 4 a.m., 12 p.m., and 9 p.m.; On 12/9/12 one tablet was dispensed at 3 a.m., 10 a.m., and 4 p.m.; On 12/10/12 one tablet was dispensed at 10 a.m., 4 p.m., and 10:45 p.m.; On 12/11/12 one tablet was dispensed at 9:30 a.m. and 8:35 p.m.; On 12/12/12 one tablet was dispensed at 2 a.m. and 5:45 (a.m./p.m. not designated). The Medication Administration Record for 11/2012 and 12/2012 did not indicate Vicodin was administered to the resident. The Nurse's notes indicated the following: On 11/22/12 at 6:45 a.m. indicated pain medication was given at 5 a.m. with relief noted. On 11/23/12 at 5 a.m. the resident had complained of pain one time and prn pain med was given. No distress noted. On 12/9/12 at 3 a.m. the resident was medicated for pain and had complained of a headache. 3. Resident #17's record was reviewed on 3/21/13 at 3:10 p.m. The resident's diagnoses included, but			

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	were not limited to, arthritis, hypertension, depression, and chronic kidney disease. The physician order, dated 1/18/13, was Oxycodone 5/325 mg 1 po q 6 hr prn pain. The physician order, dated 1/25/13, was to change Oxycodone 5/325 mg to 1 to 2 tablets pren q 6 hr prn pain. The "Controlled Substances Record" for Resident #17's Oxycodone 5/325 mg give 1 to 2 tabs orally q 6 hrs prn for pain. This record indicated the following: On 1/18/13 one tablet was dispensed at 1 a.m., 6 a.m., and 10:15 p.m.; On 1/19/13 one tablet was dispensed at 6 a.m., 3 p.m., and (unclear) p.m.; On 1/20/13 one tablet was dispensed at 3:30 a.m., 3 p.m., and (unclear) p.m.; On 1/21/13 one tablet was dispensed at 3 a.m. and 4 p.m.; On 1/22/13 one tablet was dispensed at 3 p.m.; On 1/24/13 one tablet was dispensed at 9 a.m. and 2:30 p.m.; On 1/25/13 two tablets were dispensed at 9:30 p.m.; On 1/26/13 two tablets were dispensed at 9 a.m., 3 p.m., and 9 p.m.; On 1/27/13 two tablets were			

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	dispensed at 3 a.m., 9 a.m, and 3 p.m.; On 1/28/13 two tablets were dispensed at 3 a.m., 2:50 (a.m./p.m. not designated), and 10 p.m.; On 1/29/13 two tablets were dispensed at 6 a.m. and 5 p.m.; On 1/30/13 two tablets were dispensed at 5 a.m. and 4:30 p.m.; On 1/31/13 two tablets were dispensed at 6 a.m. and 5:30 p.m.; On 2/1/13 two tablets were dispensed at 7 a.m.; On 2/2/13 two tablets were dispensed at 9 a.m., 3 p.m., 11:30 p.m.; On 2/3/13 two tablets were dispensed at 5 p.m. and 1 tablet was dispensed at 9 p.m.; On 2/4/13 two tablets were dispensed at 3 a.m.; On 2/5/13 two tablets were dispensed at 7 a.m. and 5:20 p.m.; On 2/7/13 two tablets were dispensed at 9 a.m.; On 2/8/13 one tablet was dispensed at 6 (a.m./p.m. not designated); On 2/9/13 two tablets were dispensed at 3 p.m. and 9 p.m.; On 2/10/13 two tablets were dispensed at 3:30 a.m., 9 a.m., 3 p.m. and 9 p.m.; On 2/11/13 one tablet was dispensed at 3 a.m. and two tablets were dispensed at 3 p.m.; On 2/12/13 two tablets were			

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	dispensed at 9 a.m.; On 2/13/13 two tablets were dispensed at 10:30 p.m.; On 2/14/13 two tablets were dispensed at 3:30 p.m.; On 2/15/13 two tablets were dispensed at 1:30 a.m. and 10:30 p.m. with 1 tablet dispensed at 10 (unclear); On 2/16/13 two tablets were dispensed at 3:30 a.m., 9:30 (unclear), and 3 p.m.; On 2/17/13 two tablets were dispensed at 3 a.m. and 3 p.m. with 1 tablet dispensed at 9 a.m. The Medication Administration Record for 1/2013 and 2/2013 did not indicate Oxycodone was administered to the resident related to the times above. The nurse's notes indicated the following: On 1/18/13 at 5 (unclear) the resident requested prn pain medication one time. On 1/23/13 at 2:50 (unclear if a.m. or p.m.) a physician's order for a 1 time pain pill for break through pain was given. On 1/24/13 at 2 p.m. resident was complaining of increased pain. The daughter was contacted to obtain the resident's pain medication dose at			

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	home. On 1/25/13 at 7 a.m. the resident was complaining of knee pain and medication was given at 5 a.m. with relief. On 1/26/13 at 9:30 a.m. the resident was alert with no complaint of pain or discomfort at this time. On 1/28/13 at 11 a.m. the increase in the pain medication was indicated as adequately controlling the pain. On 2/10/13 at 4 a.m. resident was restless and give pain medication. She was indicated as resting quietly at 4:30 a.m. 4. Resident #51's record was reviewed on 3/21/13 at 3:20 p.m. The resident's diagnoses included, but were not limited to, spinal stenosis, hypertension, and diabetic mellitus. The physician's order, dated 2/16/13, was Norco 5/325 mg 1 to 2 tablets every 6 hours as needed for pain. The "Controlled Substances Record" for Resident #51's Norco (hydrocodone-APAP 5/325 mg) give 1 to 2 tabs per gastrostomy tube q 6 hrs prn for pain. This record indicated the following: On 2/16/13 two tablets were dispensed at 8 p.m.;			

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	On 2/17/13 two tablets were dispensed at 1 a.m. and 7 a.m.; On 2/18/13 two tablets were dispensed at 9:30 a.m.; On 2/23/13 two tablets were dispensed at 3 p.m. and 9 p.m.; On 2/24/13 two tablets were dispensed at 3 a.m., 4 p.m., and 10 p.m.; On 3/2/13 two tablets were dispensed at 7 p.m.; On 3/3/13 two tablets were dispensed at 2 different (unclear) times. The Medication Administration Record for 2/2013 did not indicate Norco was administered to the resident related to the times above. 5. Resident #117's record was reviewed on 3/21/13 at 3:28 p.m. The resident's diagnoses included, but were not limited to, bladder adeno carcinoma, anxiety, and chronic kidney disease Stage 3. The physician's order, dated 1/19/13, was Hydrocodone-APAP 5-325 mg (Norco 5-325) 1 to 2 tablets orally every 4 hours as needed. The "Controlled Substances Record" for Resident #117's Hydrocodone-APAP 5/325 mg give 1 to 2 tabs per gastrostomy tube q 6 hrs			

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	prn for pain. This record indicated the following: On 1/19/13 two tablets were dispensed at 5 a.m., 11:45 (a.m./p.m. not designated), and 9 p.m.; On 1/20/13 two tablets were dispensed at 1 a.m. and 5 a.m.; On 1/21/13 two tablets were dispensed at 2 a.m., 9 a.m., and 9:30 p.m.; On 1/22/13 two tablets were dispensed at 6 a.m. and 9:15 p.m.; On 1/23/13 two tablets were dispensed at 6 a.m. and 9 p.m.; On 1/25/13 two tablets were dispensed at 9:45 p.m.; On 1/26/13 two tablets were dispensed at 9:30 p.m.; On 1/27/13 two tablets were dispensed at 1 a.m., 5:10 a.m., and 9:40 p.m.; On 1/28/13 two tablets were dispensed at 1:30 a.m.; On 1/29/13 two tablets were dispensed at 9 p.m.; On 1/30/13 two tablets were dispensed at 6 a.m. and 10 p.m.; On 1/31/13 two tablets were dispensed at 9:20 p.m.; On 2/1/13 one tablet was dispensed at 6 a.m.; On 2/2/13 one tablet was dispensed at 5 a.m.; On 2/3/13 two tablets were dispensed			

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	at 12(unclear) and 11 p.m.; On 2/4/13 two tablets were dispensed at 3:50 a.m.; On 2/5/13 two tablets were dispensed at 5:45 a.m. and 9:50 p.m.; On 2/6/13 two tablets were dispensed at 5 a.m.; On 2/7/13 two tablets were dispensed at 9:30 p.m.; On 2/8/13 two tablets were dispensed at 5 a.m. and 8:30 p.m.; On 2/9/13 one tablet was dispensed at 5 a.m.; On 2/10/13 one tablet was dispensed at 1 a.m.and 2 tablets at 9:15 p.m. No information was availabe from 2/10/13 to 2/23/13 with 2 tablets dispensed on 2/23 at 10 p.m. and on 2/24/13 2 tablets were dispensed at 2:30 a.m. and at 9:30 p.m. The Medication Administration Record for 1/2013 and for 2/2013 did not indicate Norco was administered to the resident related to the times above. On 3/22/13 at 10:10 a.m., the Director of Nursing indicated she did not have any information related to the above medication disposition on Resident #128, #51, #17, #56, or #117. 3.1-25(b)(3)			

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F000441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record reviews, the facility failed to	F000441	(1) All staff will be in-serviced regarding what isolation room	04/16/2013

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	ensure infection control practices were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of residents identified with infections, but lacked information regarding room locations (room numbers) to track these infections. At the time of the infection log review, the DON (Director of Nursing) indicated the location of the room numbers would have to be known to track the identified infections. She indicated the infection record for the month of February 2013 had not been completed.		supplies are to be available outside of the resident's room as well as where to get those supplies if they need to be replenished. The housekeeper in question will be in-serviced that if she is unsure of required PPE for an isolation room, she is to ask the charge nurse. CNA's will be in-serviced regarding proper handling of soiled linen. Monthly infection control logs will include the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room number where the infection was present as well as the particular organism. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. Any time there are trends observed, staff will be in-serviced to ensure that everything possible is being done to prevent further spread of infection. CNA's will be in-serviced regarding proper	

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	On 3/21/2013 at 8:30 a.m., documentation indicated a wide spread outbreak of symptoms which included nausea, emesis (vomiting), and loose stools during March 2013. This outbreak affected all the areas of the facility and included Residents #14, #49, #96, #123, #125, #126, #128, and #135. 2. On 3/18/2013 at 11 a.m., the isolation rooms were observed. Supplies, located outside the isolation rooms included gowns and masks, but lacked gloves. 3. During an observation on 03-20-12 at 1:30 p.m., Resident #49 was transferred to a clean bed via a hoyer lift. Pericare was provided by Certified Nurse Aides (CNA) #18 and #20. The soiled linens were removed from beneath the resident after the resident had been turned from side to side, and CNA #20 placed the urine saturated linens at the end of the clean bed. The CNA cleaned the resident and provided pericare, then picked up the soiled linens and then placed them on the other side of the resident in the clean bed. On 03-20-13 at 11:15 a.m., during an interview an unidentified		handling of soiled linen. Staff nurses will monitor q 2 hours during rounds to ensure proper handling of soiled linen. All staff will be in-serviced regarding what isolation room supplies are to be available outside of the resident's room as well as where to get those supplies if they need to be replenished. (4) The infection control logs will be reviewed quarterly at the QA meeting.	

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	155389	A. BUILDING 00 B. WING	03/22/2013

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	Housekeeper indicated she was unaware of why a resident was in isolation and what precautions were needed. The Housekeeper stated, "I don't know what's going on with the resident in that room, all I know is I put my gloves on when I go in there to clean the room." The "Initiating Isolation Precautions" policy was provided by the DON on 3/20/13 at 3:45 p.m. This current policy indicated the following: "...6.a. Maintain an adequate array of isolation supplies (i.e., gloves, gowns, masks, etc. as needed) near the isolation room so that appropriate protective clothing can be easily put on before entering the isolation room; ...." Clarification of contact isolation - "...contact isolation -...All disease or condition included in this category are spread primarily by close or direct contact...." 3.1-18(b)(1)(A) 3.1-19(f)			

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F000465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure a clean and sanitary environment related to the aviary area for 1 of 1 aviary observed. This had the potential to impact 47 of 47 residents in the facility. Findings include: On 3/20/13 at 3:00 p.m., the aviary was observed. Soiled areas of fecal-like material was observed on the glass windows, the bird's wooden perches, and on the aviary wall in the back of the aviary contained area. On 3/21/13 at 10:10 a.m., during an interview, Housekeeper #26 indicated the aviary area was cleaned every Friday. She indicated she had helped clean it today although she indicated it was only cleaned once a week. On 3/21/12 at 4:30 p.m., during an interview, the Administrator indicated the aviary area was cleaned 3 times a week by housekeeping. He also indicated the Plexiglas area was stained in certain areas of the aviary.	F000465	(1) We have experienced difficulty finding a consistent outside contractor to maintain the aviary in a satisfactory manner.The cabinets and glass are discolored and in poor condition. This issue was brought to our resident council president on 4/8/13 to discuss these issues. It was decided that the birds will be adopted out to new homes and the aviary will be dismantled and disposed of.	04/16/2013

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	The "Aviary cleaning policy" was provided by the Director of Nursing on 3/21/13 at 8:15 a.m. This current policy indicated the following: "It is the policy of Westpark Healthcare that the aviary will be cleaned 3 times weekly by the housekeeping department on Monday, Wednesday and Friday. At this time the birds will be given fresh water and seed. The glass will be cleaned inside and out. The gravel at the bottom of the cage will be changed quarterly. The iside (sic) of the cage will be checked to insure it is a safe and sanitary environment. The maintenance department will make adjustments as necessary." 3.1-19(f)			

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F000516 SS=C	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation and interview, the facility failed to ensure resident's medical records were stored securely and in a manner to prevent possible damage to the medical records for 1 of 1 observation of the medical storage room. This had the potential to impact 47 of 47 residents residing in the facility and 51 of 51 residents discharged from 1/20/13 through 3/21/13. Findings include: On 3/20/13 at 3:00 p.m. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the medical record storage room was observed unlocked with a ceiling sprinkler system in place and with 17 cardboard boxes full of files on top of the file cabinets. During an interview	F000516	(1) All discharged resident records and currentresident's records that have been thinned will be stored in a file cabinet in amedical records room that will remain locked at all times. (2) No other residents were affected by the deficient practice (3) A lock has been installed on the medical records door that remains locked by default. No medical records will be stored in boxes. They will all be stored in metal filing cabinets. (4) The corrective action will be monitored by the DON and Administrator. The DON or Administrator will check the medical records room weekly.	04/16/2013

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	at this same time, the DON indicated the medical storage room should have been locked. The DON also indicated the 17 cardboard boxes contained residents' medical records and should have been stored in a secure location and protected from potential environmental damage. On 3/21/13 at 8:35 am during an interview, the DON indicated the cardboard boxes contained discharged residents' records from January 2013. On 3/22/12 at 1:40 p.m., the list of discharged residents from 1/20/12 through 3/21/13 was provided by the ADON and indicated 51 residents had been discharged during this period. 3.1-50(d)			

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F000520 SS=B	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to ensure an effective Quality Assessment and Assurance program for tracking/preventing the spread of infections. The facility failed to ensure an effective Quality Assessment and Assurance program for pressure prevention interventions and failed to ensure a system for reconciliation of narcotic sign out sheets with the Medication	F000520	(1) Specific organisms related to infections will be added to the infection control log along with where in the building the infection was located. All resident skin sheets and treatments will be reviewed to ensure that all residents have appropriate pressure ulcer prevention methods in place. (2) The DON/ADON will monitor that narcotics signed out are documented as given on the MAR to identify other residents with the potential to be affected. Skin	04/16/2013

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	Administration Record. Findings include: During an interview on 03-22-13 at 10:00 a.m., the Quality Assessment and Assurance nurse indicated the team members met in February 2013. When questioned about Infection control, the Quality Assessment and Assurance Nurse indicated the Director of Nurses tracked the infections and listed the infections by the facility halls. The nurse further indicated she was unsure if specific organisms were tracked, and indicated it was not discussed in the Quality Assessment and Assurance meetings. The Quality Assessment and Assurance (QAA) nurse indicated nursing staff were responsible for ensuring compliance with resident positioning and pressure reducing interventions. The nurse indicated that during the last quarter 2012 the facility had a slight increase in pressure ulcers. The QAA nurse indicated gradual dose reductions and quantities of routine and prn (as needed) narcotic pain medications were discussed in		sheets and treatment/preventative methods will be reviewed to identify other residents with the potential to be affected. (3) Licensed nurses will be in-serviced regarding proper documentation of medications. In regards to infection, specific organisms and location will be discussed during the quarterly QA meeting.During the quarterly QA meeting, management will discuss any discrepancies in regards to narcotics signed out and what is documented as administered. Also during the QA meeting, while discussing infections, particular organisms will be discussed, along with where in the building the infections were located and whether any patterns were identified.During QA management will continue to discuss pressure ulcers and other skin conditions.	

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	meetings. The QAA nurse indicated there had not been discussion in regard to ensuring narcotics signed out were documented as given on the resident's Medication Administration Record (ensuring the quantity of narcotic medication signed out matched the quantity of medication indicated as given on the MAR). 3.1-52(b)(2)			